

**Universal Screening for Social Determinants of Health in Pediatric Primary Care: A  
Quality Improvement Project**

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### **Abstract**

In the context of health equity, social determinants of health (SDOH) are the non-health-related conditions, like poverty, proven to be detrimental to children's development. Pediatric healthcare advocates like the American Academy of Pediatrics have examined the harms associated with SDOH and responded with policy statements reflecting the need for a universal approach to screen and address risk factors across all healthcare settings. Currently, many screening efforts lack a comprehensive approach to identifying resource disparities associated with multiple SDOH. A group of stakeholders from a private practice pediatric primary care clinic in the Pacific Northwest developed this project to universally screen for SDOH during well-child visits following an ecological health systems theory and The Model for Improvement, a quality improvement framework. The clinic aimed to screen 80% of patients between the ages of 1 month to 18 years annually and provide resource referrals to families who screened positive. Between October 18th, 2021, and December 10th, 2021, the clinic achieved a screening rate of 73% from a baseline of zero. Although the project fell short of its aim, key findings were discovered, and the clinic provider's capacity to incorporate universal screening and engage families in discussing resource needs was increased. The key learnings aligned with the research on implementing SDOH screening tools and quality improvement initiatives. This project offers insight into the process of implementing universal SDOH screening in routine pediatric care. However, the generalizability of results across settings and populations is limited to a similar setting and population.

## Introduction

### Problem Description

The World Health Organization defines social determinants of health (SDOH) as “non-medical factors that influence health outcomes” (World Health Organization, 2010, 2021). They are the conditions where people live, learn, work, and play, affecting health and well-being in both positive and negative ways (World Health Organization, 2021). In the context of health equity, social determinants like poverty have a particularly negative influence on children’s early development (Bush et al., 2018; Pascoe et al., 2016). Researchers Pascoe et al. (2016) explain that “children inherit not only their parents' genes but the family's ecology with its social milieu.” (abstract). A multitude of research shows that disadvantaged children have a greater likelihood of suffering consequential effects of repetitive adversity and toxic stress, leading to a wide range of maladaptive behaviors and poor health outcomes (Hughes et al., 2017; Pascoe et al., 2016; Shonkoff, 2016; Shonkoff et al., 2021).

### Available Knowledge

Several children’s health advocates have examined the harms of SDOH and responded with guidelines that call for a universal SDOH screening (American Academy of Pediatrics Council on Community Pediatrics, 2016; Beck et al., 2018; Beck et al., 2016; Byhoff et al., 2018; Chung et al., 2016; Graif et al., 2021). In 2016, the American Academy of Pediatrics (AAP) reaffirmed its policy statement titled “Community Pediatrics,” providing a framework for providers to promote children’s health and well-being within the context of family and community (American Academy of Pediatrics Council on Community Pediatrics, 2016; Graif et al., 2021).

However, few formal guidelines model a universal approach, and many screening efforts lack a comprehensive tool to identify multiple disparities (Dworkin & Garg, 2019; Henrikson et al., 2019; Morone, 2017; Sokol et al., 2019). Social disparities often intersect as determinants like poverty layer on downstream effects such as limited education, employment, health care, and food insecurity (Morone, 2017; Pascoe et al., 2016). A validated screening tool has strong pragmatic properties (low cost, readability, and brief administration time), helping to measure intended concepts, but may lack the reliability to measure intended concepts across different practice settings (Henrikson et al., 2019; Sokol et al., 2019).

The 'WE CARE' (Well-Child Care Visit, Evaluation, Community Resources, Advocacy, Referral, and Education) screening tool is a clinical survey developed in collaboration with social workers, legal advocates, and medical providers to screen and identify families experiencing multiple social risks within the context of available resources (Garg et al., 2007; Garg et al., 2015). The survey is one of two comprehensive and validated tools with strong reliability across different populations and practice settings (Garg et al., 2007; Garg et al., 2015; Henrikson et al., 2019; O'Brien, 2019; Sokol et al., 2019). A particular strength of the WE CARE survey is that it engages providers in discussion with families regarding unmet needs by asking if families perceive the need for help. The literature showed that these discussions increased the likelihood that families requested resources (Garg et al., 2018).

### **Rationale**

This project proposal followed an ecological health systems theory supported by the AAP. The project was a quality improvement initiative that facilitates universal screening for SDOH implemented in a privately owned pediatric primary care practice clinic located in the Pacific Northwest. As described by Urie Bronfenbrenner's Ecological Systems Theory, children

develop within the context of relationships and environments affected by the complexity of their interactions (Cross, 2017; Graif et al., 2021). The AAP draws on this theory to describe environments and social settings where screening and surveillance are “integral aspects of child health promotion and disease prevention” (Graif et al., 2021, p.1). Beginning with microsystems like family, school, and healthcare and extending into macrosystems like public policy, the ecology of children’s environments can enhance or damage their development (Graif et al., 2021). Using this framework, primary care providers are uniquely positioned within the microsystem to identify ecology-based risk factors and refer families to the targeted services that address their needs (Graif et al., 2021).

This project used the Model for Improvement framework allowing stakeholders to capitalize on iterative tests of change with Plan, Do, Study, Act (PDSA) cycles, identifying adjustments in process, outcomes, and balancing measures to affect meaningful change (Langley et al., 2009).

### **Specific Aims**

This project implemented the WE CARE survey during routine health visits to screen families for multiple SDOH. The project aimed to screen 80% of patients between the ages of 1 month to 18 years who are seen at the clinic during annual well-child visits and provide resource referrals to patients with positive screenings. Resource referrals were organized into a list provided to patients with their after-visit summaries (AVS). A process measure will follow the provider’s evolving confidence in screening for SDOH by asking that they complete 5 Likert style questions as a survey of confidence after each PDSA cycle. The questions help identify the positive effects of change and any balancing measures related to provider confidence.

## **Methods**

### **Context**

The clinic is one of five pediatric clinics networked together under one organization owned and managed by a private group of pediatricians. Although the organization encompasses multiple practice sites, the project will be implemented and studied at one location. There are three primary care providers at this location; one provider is the clinic's director. The clinic operates Monday through Friday, with one to two providers scheduled each day. Each of the providers works with the same medical assistant regularly. Several front-office workers interface with families to schedule appointments, check patients in, and coordinate referrals and continuity with local health partners. The providers follow the AAP Bright Futures framework with developmental screenings planned during well-child visits upon a continuum of ages, from newborns to adolescents, with appointments scheduled for 20 minutes.

A facilitating factor in implementing this project was that the clinic has already established strong community partnerships and awareness of the available resources amongst community outreach groups. Potential barriers to the project's success included the potential for SDOH and developmental screening to lengthen appointment times and have providers struggling to address all screening tools and outcomes.

### **Intervention**

As seen in Appendix A, the WE CARE survey was administered in paper format to screen for six domains of SDOH, including childcare, employment, housing, food security, education, and utility assistance (Garg et al., 2015). The survey's questions asked whether the respondent identified a need within each domain and then asked if the respondent would like assistance with that need (Garg et al., 2015). The project was designed to provide screening

during well-child visits with children ages 6, 9, 15, and 36 months followed by annual screening from ages 3 through 18 years. The resource list was designed by the project's manager and provided families with information about the availability of local resources (see Appendix B). Many of the services included were informed by the work of the clinic director, as he identified recurring needs of the clinic's population. Before completing the resource tool, the project's manager confirmed the current availability of the services and updated contact information as needed.

Front office staff offered the WE CARE survey to the designated ages at check-in and requested that caregivers complete the survey before seeing the provider. The survey is written at a third-grade literacy level and designed to be completed in five or fewer minutes (Garg et al., 2007). During the appointment, providers explained the purpose of screening for SDOH while reviewing the survey's results and answering questions. Charting was streamlined using a smart phrase built into the EHR, designed to identify screening completion and highlight when families received the resource list. The process minimized charting time, allowing discussion with families regarding any resource requests. Providers introduced families to available resources using the resource tool, and all families were directed to call the clinic with any questions and future needs. Families that declined to participate in screening still received their AVS without the resource list.

### **Study of the Intervention**

The project's outcomes were designed to achieve an effective baseline screening rate using the WE CARE survey while improving providers' confidence in screening and discussing SDOH. The clinic director collected field notes regarding how the screening process affected

clinic workflows throughout the project. Measuring providers' screening rates, confidence results, and field notes provided evidence of the intervention's effectiveness and change quality. Patient feedback and survey results helped identify unexpected balancing measures and allowed for adjustments in the intervention before the next PDSA cycle.

### **Measures**

Project data were collected in four separate chart reviews, one occurring every two weeks. The primary process measure was the provider's charting of the WE CARE survey administration. The project manager completed chart reviews on patients who met the screening criteria by looking for the smart phrase documenting survey completion and resource requests. The primary outcome measure was collected by looking for increased resource referrals to families who screened positive for resource needs. Data from field notes, confidence surveys, and patient feedback informed the study team about contextual elements and the possibility of balancing measures. Themes and patterns that develop in the field notes and confidence surveys were reviewed as a collaborative effort amongst the study team allowing for timely adjustment of the intervention before the next change cycle.

### **Analysis**

Data collected for this project was kept in a Microsoft Excel spreadsheet. The data was analyzed and displayed using run charts to document the process and outcome measures, including annotations of the changes made between PDSA cycles.

### **Ethical Considerations**

All staff clinic staff were informed of this quality improvement project. Major stakeholders, including the clinic's director and providers, extended support. The personal autonomy of patients and families was respected by their right to refuse screening without



affecting the care received. The project was submitted to the Investigational Review Board at OHSU and deemed a quality improvement project.

## Results

The project was implemented from October 18th, 2021, to December 10th, 2021. In four PDSA cycles that extended two weeks each, the clinic increased the SDOH screening rate from a baseline of zero at implementation to an average screening rate of 73% by screening 209 out of 286 families who had met the designation criteria to screen (see Figure 1).

During the project, multiple modifications were necessary (see Figure 2). Before implementation, a one-page resource tool was redesigned to be handed to patients instead of printed onto the AVS, easing time and technology barriers associated with uploading the list to the EHR. During the first PDSA cycle, the WE CARE survey's layout was reformatted to improve readability and flow as providers noted that survey respondents were circling unintended answers (see Appendix C). At the end of PDSA cycle two, the confidence surveys were cut from data collection and replaced by field notes. The clinic's director suggested this modification after he made multiple attempts to collect surveys from providers without receiving their responses. The clinic's director shared field notes with the project manager every two weeks. No changes were made in PDSA cycles three and four, and data collection continued through the end of PDSA cycle four, when the project was concluded.

After evaluating the cumulative mean and median of each provider's screening rate, it was evident that one provider had the least consistent screening, effectively lowering the clinic's mean screening percentage (see Figure 1). The cumulative median or middle screening percentage of the two other provider's screening rates shows the clinic's screening average without the outlier effect of the provider with the lowest screening percentage. This data view

shows that two out of three providers reached the project aim of an 80% screening rate or greater (see Figure 2).

## **Discussion**

### **Summary**

This project was a collaborative effort developed and implemented to actualize a process of universal screening for SDOH in pediatric primary care. Three key findings were realized, contributing to crucial insight in effectuating a change across different populations, contexts, and stakeholder groups. The first key finding was learning that an evidence-based, validated, and reliable screening tool may need modifications when used in other settings with different populations. A second key finding was the challenge of maintaining stakeholder commitment when the role of the project's sponsor, the clinic's director, transitioned from leadership to that of equal footing amongst peers. A third key finding was rooted in the unpredictability of real-world healthcare practice and discovering how the global COVID-19 pandemic influenced contextual elements and impacted the project's implementation and results.

### **Interpretation**

This project demonstrates how universal screening for SDOH compliments current preventative and surveillance measures in pediatric primary care. Although the project fell short of its aim and goal screening percentage, the providers' capacity to incorporate universal screening of SDOH and engage families in discussing resource needs was increased.

In line with the research, contextual factors within the clinic setting and population informed the quality of changes made with the project's intervention and processes. Quality improvement scholars Langley et al., (2009) explains how beneficial change unfolds through iterative redesign of tools and processes as change cycles become learning cycles of curiosity

and attention (2009). The modifications made during this project to the WE CARE survey were unpredictable and necessary to drive outcome measures of discussing resources with families and offering referrals for unmet needs. Reporting on the fallibility of validated screening tools, researchers Garg et al. discuss how screeners need positive predictive risk value and reliability, but ultimately to be helpful, they must lead to interventions connecting families with resources (2018; 2019).

The hardship of having an unplanned leadership transition during the project's progression likely challenged the aim. When the clinic's director and project sponsor needed to step away from his formal management position to prioritize his time elsewhere, his sponsorship also decreased. Although he maintained an interim leadership role until the clinic could appoint a new formal director, this did not occur in the project's timeline. Leadership transitions have been shown to affect quality improvement outcomes in the literature. The framework of the Model for Improvement defines leadership's sponsorship role and responsibility as advocating for a project's aims and outcomes by helping maintain stakeholder awareness and buy-in to change processes (Langley et al., 2009).

As this project was implemented during the Delta variant surge, a year and a half into the pandemic, families were heavily reliant on their children's providers to help them make sense of each new pandemic-related health recommendation. Despite screening for and discussing SDOH, providers felt families were in most need of COVID-19 testing and management. The ratio of sick and telehealth visits to well-child visits was skewed from expectations set in prior years, and as providers took on extra tasks to fill quarantine-induced staff shortages, they felt pressed for time. (R. Hassan, personal communication, November 1, 2021).

**Limitations**

The project was designed to collect data using chart review and smart phrases in the EHR to reduce the number of materials and prevent missing data. However, out of 209 screens, only two resource requests were documented in the data. By failing to create a process of collecting completed surveys, there was no way to interpret the cause of this outcome from the data alone. Field notes indicated that patients were already accessing resources, but the degree this was happening could not be ascertained. Screening efforts were likely troubled by the contextual factors of changes in clinic leadership and Covid-19. The clinic's director felt the project would have benefited from protected meeting time for stakeholders to gather and collaborate on facilitating and barrier factors (R. Hassan, personal communication, February 1, 2022).

**Conclusions**

This project offers vital insights into the process of implementing universal screening for SDOH in a pediatric primary care clinic. The generalizability across settings and populations is limited to small practice settings with a pediatric population. A recommendation for similar projects in the future is to benefit from protected meeting time for stakeholders to work on reviewing the project's progress and ensure complete data collection on the intervention.

## References

- American Academy of Pediatrics Council on Community Pediatrics. (2016). Community pediatrics: Navigating the intersection of medicine, public health, and social determinants of children's health. *Pediatrics*, *131*(3), 623-628. <https://doi.org/10.1542/peds.2012-3933> (Original work published 2013)
- Beck, A. F., Cohen, A. J., Colvin, J. D., Fichtenberg, C. M., Fleegler, E. W., Garg, A., Gottlieb, L. M., Pantell, M. S., Sandel, M. T., Schickedanz, A., & Kahn, R. S. (2018). Perspectives from the society for pediatric research: Interventions targeting social needs in pediatric clinical care. *Pediatric Research*, *84*(1), 10-21. <https://doi.org/10.1038/s41390-018-0012-1>
- Beck, A. F., Tschudy, M. M., Coker, T. R., Mistry, K. B., Cox, J. E., Gitterman, B. A., Chamberlain, L. J., Grace, A. M., Hole, M. K., Klass, P. E., Lobach, K. S., Ma, C. T., Navsaria, D., Northrip, K. D., Sadof, M. D., Shah, A. N., & Fierman, A. H. (2016). Determinants of health and pediatric primary care practices. *Pediatrics*, *137*(3), e20153673. <https://doi.org/10.1542/peds.2015-3673>
- Bush, N. R., Edgar, R. D., Park, M., MacIsaac, J. L., McEwen, L. M., Adler, N. E., Essex, M. J., Kobor, M. S., & Boyce, W. T. (2018). The biological embedding of early-life socioeconomic status and family adversity in children's genome-wide DNA methylation. *Epigenomics*, *10*(11), 1445-1461. <https://doi.org/10.2217/epi-2018-0042>
- Byhoff, E., Freund, K. M., & Garg, A. (2018). Accelerating the Implementation of Social Determinants of Health Interventions in Internal Medicine. *Journal of General Internal Medicine*, *33*(2), 223-225. <https://doi.org/10.1007/s11606-017-4230-8>

- Chung, E. K., Siegel, B. S., Garg, A., Conroy, K., Gross, R. S., Long, D. A., Lewis, G., Osman, C. J., Jo Messito, M., Wade, R., Jr., Shonna Yin, H., Cox, J., & Fierman, A. H. (2016). Screening for social determinants of health among children and families living in poverty: A guide for clinicians. *Current Problems in Pediatric and Adolescent Health Care*, 46(5), 135-153. <https://doi.org/10.1016/j.cppeds.2016.02.004>
- Cross, W. E., Jr. (2017). Ecological Factors in Human Development. *Child Development*, 88(3), 767-769. <https://doi.org/10.1111/cdev.12784>
- Dworkin, P. H., & Garg, A. (2019). Considering approaches to screening for social determinants of health. *Pediatrics*, 144(4), e20192395. <https://doi.org/10.1542/peds.2019-2395>
- Garg, A., Butz, A. M., Dworkin, P. H., Lewis, R. A., Thompson, R. E., & Serwint, J. R. (2007). Improving the management of family psychosocial problems at low-income children's well-child care visits: The WE CARE project. *Pediatrics*, 120(3), 547-558. <https://doi.org/10.1542/peds.2007-0398>
- Garg, A., Homer, C. J., & Dworkin, P. H. (2019). Addressing Social Determinants of Health: Challenges and Opportunities in a Value-Based Model. *Pediatrics*, 143(4), e20182355. <https://doi.org/10.1542/peds.2018-2355>
- Garg, A., Sheldrick, R. C., & Dworkin, P. H. (2018). The Inherent Fallibility of Validated Screening Tools for Social Determinants of Health. *Academic Pediatrics*, 18(2), 123-124. <https://doi.org/https://doi.org/10.1016/j.acap.2017.12.006>
- Garg, A., Toy, S., Tripodis, Y., Silverstein, M., & Freeman, E. (2015). Addressing social determinants of health at well child care visits: A cluster RCT. *Pediatrics*, 135(2), e296-304. <https://doi.org/10.1542/peds.2014-2888>

Graif, C., Meurer, J., & Fontana, M. (2021). An Ecological Model to Frame the Delivery of Pediatric Preventive Care. *Pediatrics*, *148*(Supplement 1), s13-s20.

<https://doi.org/10.1542/peds.2021-050693D>

Henrikson, N. B., Blasi, P. R., Dorsey, C. N., Mettert, K. D., Nguyen, M. B., Walsh-Bailey, C., Macuiba, J., Gottlieb, L. M., & Lewis, C. C. (2019). Psychometric and pragmatic properties of social risk screening tools: A systematic review. *American Journal of Preventive Medicine*, *57*(6 Suppl 1), S13-S24.

<https://doi.org/10.1016/j.amepre.2019.07.012>

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet Public Health*, *2*(8), e356-e366.

[https://doi.org/https://doi.org/10.1016/S2468-2667\(17\)30118-4](https://doi.org/https://doi.org/10.1016/S2468-2667(17)30118-4)

Langley, G. L., Moen, R., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd ed.). Jossey-Bass Publishers.

Morone, J. (2017). An integrative review of social determinants of health assessment and screening tools used in pediatrics. *Journal of Pediatric Nursing*, *37*, 22-28.

<https://doi.org/10.1016/j.pedn.2017.08.022>

O'Brien, K. H. (2019). Social determinants of health: The how, who, and where screenings are occurring: A systematic review. *Social Work in Health Care*, *58*(8), 719-745.

<https://doi.org/10.1080/00981389.2019.1645795>

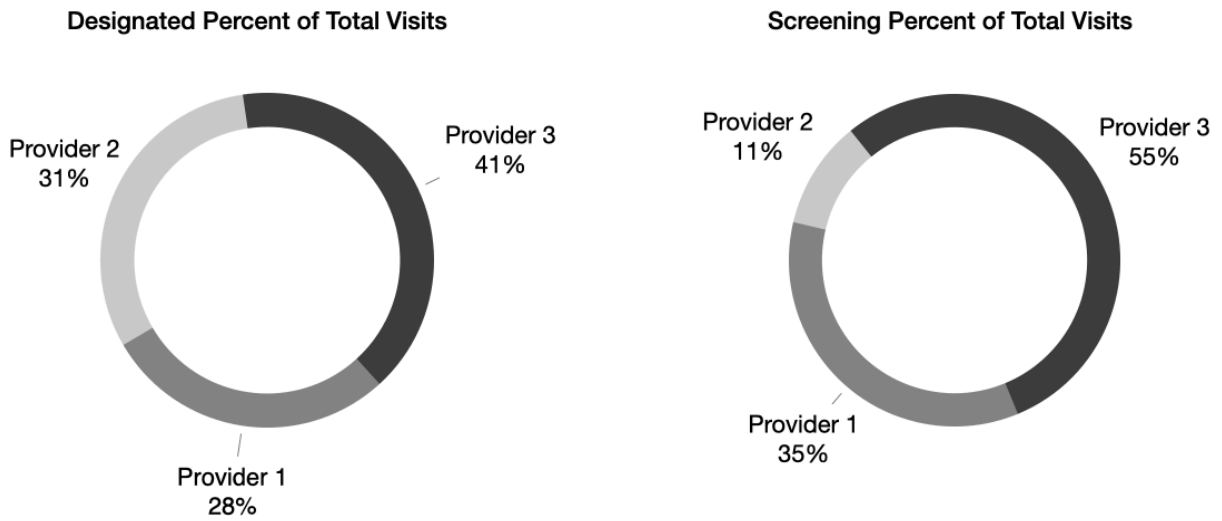
Pascoe, J. M., Wood, D. L., Duffee, J. H., Kuo, A., Committee On Psychosocial Aspects Of, C., Family, H., & Council On Community, P. (2016). Mediators and adverse effects of child

- poverty in the united states. *Pediatrics*, *137*(4), e20160340.  
<https://doi.org/10.1542/peds.2016-0340>
- Shonkoff, J. P. (2016). Capitalizing on advances in science to reduce the health consequences of early childhood adversity. *JAMA Pediatrics*, *170*(10), 1003-1007.  
<https://doi.org/10.1001/jamapediatrics.2016.1559>
- Shonkoff, J. P., Boyce, W. T., Levitt, P., Martinez, F. D., & McEwen, B. (2021). Leveraging the biology of adversity and resilience to transform pediatric practice. *Pediatrics*, *147*(2).  
<https://doi.org/10.1542/peds.2019-3845>
- Sokol, R., Austin, A., Chandler, C., Byrum, E., Bousquette, J., Lancaster, C., Doss, G., Dotson, A., Urbaeva, V., Singichetti, B., Brevard, K., Wright, S. T., Lanier, P., & Shanahan, M. (2019). Screening children for social determinants of health: A systematic review. *Pediatrics*, *144*(4). <https://doi.org/10.1542/peds.2019-1622>
- World Health Organization. (2010). *A conceptual framework for action on the social determinants of health*. <https://www.who.int/publications/i/item/9789241500852>
- World Health Organization. (2021). *Social determinants of health*  
[https://www.who.int/social\\_determinants/sdh\\_definition/en/](https://www.who.int/social_determinants/sdh_definition/en/)



**Figure 1**

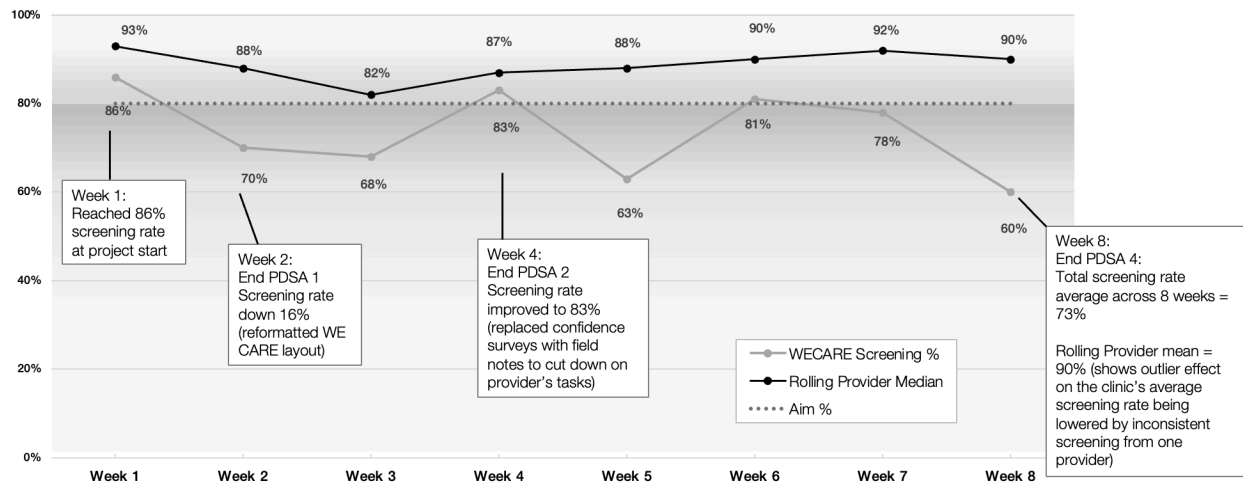
*Comparison: Percentage of Screening Visits and Screening Totals by Individual Providers*



Note: Provider 2 had 31% of the visits designated to screen, yet only screened 11% of the total screenings.

**Figure 2**

*Clinic Screening Percentages by PDSA Cycle with Changes Annotated*



Note: The rolling median screening percentage shows the clinic's screening average without the outlier effect of the provider with the lowest screening percentage (provider 2 in Figure D1). This data view finds that two providers with consistent screening rates reached the project aim.

Appendix A

## **WE CARE Survey**

DECLINED







*Place patient sticker here, or write in:*

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Visit date: \_\_\_\_\_






We want to make sure that you know about the community resources that are available to you and your family. Many of these resources are free of charge. Please answer each question and hand it to your child's doctor at the beginning of the visit. Thank you!

	<p><b>Do you need childcare for your child?</b></p> <p>YES</p> <p><input type="checkbox"/> If YES, would you like help finding it? <span style="color: blue;">→</span></p> <p>NO</p> <p><input type="checkbox"/></p>	<p>Yes    No    Maybe Later</p> <p><input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/></p>
	<p><b>Do you have a full-time job?</b></p> <p>YES</p> <p><input type="checkbox"/></p> <p>NO</p> <p><input type="checkbox"/> If NO, would you like help finding employment? <span style="color: blue;">→</span></p>	<p>Yes    No    Maybe Later</p> <p><input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/></p>
	<p><b>Do you think you are at risk of becoming homeless?</b></p> <p>YES</p> <p><input type="checkbox"/> If YES, would you like help with this? <span style="color: blue;">→</span></p> <p>NO</p> <p><input type="checkbox"/></p>	<p>Yes    No    Maybe Later</p> <p><input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/></p>
	<p><b>Do you always have enough food for your family?</b></p> <p>YES</p> <p><input type="checkbox"/></p> <p>NO</p> <p><input type="checkbox"/> If NO, would you like help with this? <span style="color: blue;">→</span></p>	<p>Yes    No    Maybe Later</p> <p><input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/></p>
	<p><b>Do you have a high school degree?</b></p> <p>YES</p> <p><input type="checkbox"/></p> <p>NO</p> <p><input type="checkbox"/> If NO, would you like help to get a GED? <span style="color: blue;">→</span></p>	<p>Yes    No    Maybe Later</p> <p><input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/></p>
	<p><b>Do you have trouble paying your heating/cooling, water or electricity bill?</b></p> <p>YES</p> <p><input type="checkbox"/> If YES, would you like help with this? <span style="color: blue;">→</span></p> <p>NO</p> <p><input type="checkbox"/></p>	<p>Yes    No    Maybe Later</p> <p><input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/></p>

Developed by Arvin Garg, MD, MPH

Appendix A. WE CARE Survey (original layout used in the project).

**Appendix B**







 <b>Child Care</b>	<b>Oregon Health and Human Services</b>	Child care for working parents <a href="https://www.oregon.gov/dhs/assistance/child-care/Pages/index.aspx">https://www.oregon.gov/dhs/assistance/child-care/Pages/index.aspx</a>
	<b>Clackamas Education Service District</b>	Early Head Start and Preschool <a href="https://www.clackesd.org/early-learning/child-care-resource-referral/#parent-resources">https://www.clackesd.org/early-learning/child-care-resource-referral/#parent-resources</a>
	<b>211 Info Community Resource Help</b>	Call 211, website 211info.org Email: HELP@211INFO.ORG
 <b>Food</b>	<b>Oregon DHS Food Assistance</b>	<a href="https://govstatus.egov.com/or-dhs-food">https://govstatus.egov.com/or-dhs-food</a>
	<b>Oregon Food Bank</b>	<a href="https://www.oregonfoodbank.org/find-help/find-food/">https://www.oregonfoodbank.org/find-help/find-food/</a> Email: <a href="mailto:gethelp@oregonfoodbank.org">gethelp@oregonfoodbank.org</a> Call (503) 505-7061
	<b>Sunshine Division</b>	Will provide a box of food per family, no questions asked <a href="https://sunshinedivision.org/get-help/">https://sunshinedivision.org/get-help/</a>
	<b>Partner for a Hunger-Free Oregon</b>	SNAP, school meals, Pandemic EBT (including eligibility, sample letters/texts, flyers), WIC, college students, food pantries, Meals on Wheels immigrants, etc. <a href="https://oregonhunger.org/covid-19/">https://oregonhunger.org/covid-19/</a>
 <b>Housing</b>	<b>Clackamas County Coordinated Housing Access</b>	Access to many housing service programs <a href="https://www.clackamas.us/communitydevelopment/cccha.html">https://www.clackamas.us/communitydevelopment/cccha.html</a> Call 503-655-8575 Email: <a href="mailto:cha@clackamas.us">cha@clackamas.us</a>
	<b>A Home for Everyone</b>	Local housing resources: Call 211, website 211info.org Email: HELP@211INFO.ORG
	<b>Community Action - Clackamas and Washington Counties</b>	Help with housing and utilities. Clackamas County <a href="https://caporegon.org/find-services/clackamas-county-social-services/">https://caporegon.org/find-services/clackamas-county-social-services/</a> Washington County <a href="https://caowash.org">https://caowash.org</a>
 <b>Employment</b>	<b>Goodwill Industries Job Connection</b>	Free job search help, career skills development, English classes. Phone: (971) 229 0757 (Clackamas), (503) 239 1734 (Multnomah), (503) 746 5070 or (503) 639 9482 (Washington) Address: (Multiple): 9999 SE 82nd Avenue, Happy Valley; 1943 SE Sixth Avenue, Portland; 13920 SW Pacific Hwy, Tigard
	<b>SE Works and Work Source Oregon</b>	Skill training resources, workshops and tools to find new and better work. Website: <a href="https://seworks.org">https://seworks.org</a> Phone: (503) 772 2300 (Multnomah and Clackamas), (503) 612 4200 (Washington) Address: (Multiple): 7916 SE Foster Road, Portland 7995 SW Mohawk St., Tualatin
<b>Education</b>	<b>How to get your GED</b>	Oregon's GED Option Program makes it easy for children and parents to get their GED. Find all the information you need on their website: <a href="https://www.oregon.gov/ode/learning-options/GED/GEDoption/Pages/GED-Option-Applications.aspx">https://www.oregon.gov/ode/learning-options/GED/GEDoption/Pages/GED-Option-Applications.aspx</a>
 <b>Utilities</b>	<b>Multnomah County Utility Assistance Program</b>	Eligibility based on income <a href="https://www.multco.us/dd/utility-assistance">https://www.multco.us/dd/utility-assistance</a>
	<b>Clackamas County Energy Assistance Program</b>	Eligibility based on income <a href="https://www.clackamas.us/socialservices/energy.html">https://www.clackamas.us/socialservices/energy.html</a>
	<b>Washington County Community Action</b>	Mon - Thurs 9:00 am - 12 pm online, or by calling 503-615-0771 <a href="https://www.caowash.org/programs/energy-assistance/">https://www.caowash.org/programs/energy-assistance/</a>

Appendix B. Resource list provided to families with positive WE CARE surveys.

Appendix C

**WE CARE Survey** DECLINED

We want to make sure that you know about the community resources that are available to you and your family. Many of these resources are free of charge. Please answer each question and hand it to your child's doctor at the beginning of the visit. Thank you!

	<b>Do you need childcare for your child?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<i>If YES, would you like help with this?</i> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe Later <input type="checkbox"/>
	<b>Do you need resources for finding employment?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<i>If YES, would you like help with this?</i> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe Later <input type="checkbox"/>
	<b>Do you think you are at risk of becoming homeless?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<i>If YES, would you like help with this?</i> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe Later <input type="checkbox"/>
	<b>Do you always have enough food for your family?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<i>If NO, would you like help with this?</i> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe Later <input type="checkbox"/>
	<b>Do you have a high school degree?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<i>If NO, would you like help with this?</i> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe Later <input type="checkbox"/>
	<b>Do you have trouble paying your heating/cooling, water, or electricity bill?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<i>If YES, would you like help with this?</i> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe Later <input type="checkbox"/>

Developed by Arvin Garg, MD, MPH

Appendix C. WE CARE Survey (updated layout modified during the project).